Dallas
Cabe W. Chadick, F.S.A.
S. Scott Gibson, F.S.A.
Glenn A. Tobleman, F.S.A., F.C.A.S.
Michael A. Mayberry, F.S.A.
David M. Dillon, F.S.A.
Gregory S. Wilson, F.C.A.S.
Steven D. Bryson, F.S.A.
Brian D. Rankin, F.S.A.
Bonnie S. Albritton, F.S.A.
Jacqueline B. Lee, F.S.A.
Xiaoxiao (Lisa) Jiang, F.S.A.
Brian C. Stentz, A.S.A.
Jennifer M. Allen, A.S.A.
Josh A. Hammerquist, A.S.A.
Johnathan L. O'Dell, A.S.A.
Clint Prater, A.S.A.
Larry Choi, A.S.A.
Kevin Ruggeberg, A.S.A.
Traci Hughes, A.S.A.

Actuaries & Consultants

Kansas City
Gary L. Rose, F.S.A.
Terry M. Long, F.S.A.
Leon L. Langlitz, F.S.A.
D. Patrick Glenn, A.S.A., A.C.A.S.
Christopher J. Merkel, F.S.A.
Christopher H. Davis, F.S.A.
Karen E. Elsom, F.S.A.
Jill J. Humes, F.S.A.
Kimberly S. Shores, F.S.A.
Michael A. Brown, F.S.A.
Naomi J. Kloeppersmith, F.S.A.
Stephanie T. Crownhart, F.S.A.
Mark W. Birdsall, F.S.A.
Andrea J. Huckaba, F.S.A., C.E.R.A.

London/Kansas City
Timothy A. DeMars, F.S.A., F.I.A.
Scott E. Morrow, F.S.A., F.I.A.

Denver
Mark P. Stukowski, F.S.A.
William J. Gorski, F.S.A.

Indianapolis
Kathryn R. Koch, A.C.A.S.

Baltimore
David A. Palmer, C.F.E.

October 26, 2017

Green Mountain Care Board
State of Vermont
89 Main Street, Third Floor, City Center
Montpelier, VT 05620

Re: 1Q18 – 2Q18 MVPHIC Large Group EPO/PPO Rates – AMENDED REPORT
SERFF #: MVPH-131148723

The purpose of this letter is to provide a summary and recommendation regarding the large group filing submitted by MVP Health Insurance Company (MVPHIC) for its existing EPO/PPO experience-rated products for the first and second quarters of 2018 and to assist the Board in assessing whether to approve, modify, or disapprove the request. The letter is an amendment to the letter dated October 9, 2017 has been amended to reflect the filing changes submitted by MVP on October 18th.

Filing Description

1. This filing demonstrates the premium rate development of MVPHIC's large group EPO/PPO product portfolio, comprising of both high deductible health plans (HDHP) and non-high deductible plans (Non-HDHP), and includes proposed rates for both the first and second quarters of 2018.

2. As of May 2017, there were approximately 1,995 members enrolled in MVP Large Group PPO plans. Of these 1,995 members, 1,682 (84%) have a first quarter effective date, and 166 (8%) have effective dates in the second quarter. The remaining members have effective dates in the third or fourth quarter.

3. The average requested quarterly manual rate changes are seen below, alongside previously approved rate changes. The annualized rate changes for 1st quarter group renewals and 2nd quarter group renewals are in the second chart.

Reason for Change	2Q17 / 1Q17	3Q17 / 2Q17	4Q17 / 3Q17	1Q18/ 4Q17	2Q18/ 1Q18
Manual Rate Change	1.6%	4.6%	1.8%	-3.1%	1.4%
Age/Gender Factor Changes	0.0%	-1.3%	0.0%	-0.1%	0.0%
Change in Retention	0.9%	0.2%	0.9%	0.3%	0.0%
Total Revenue Changes	2.5%	3.5%	2.7%	-2.9%	1.4%

Reason for Change	1Q18 Annual	2Q18 Annual
Manual Rate Change	4.8%	4.6%
Age/Gender Factor Changes	-1.4%	-1.4%
Change in Retention	2.4%	1.4%
Total Revenue Change	***5.8%***	***4.7%***

4. The filing was amended on October 18th. The benefit design for plan VEHD2-41 and an associated rider were found to be out of compliance with the QHDHP regulations for 2018, necessitating a small change to the rate. The change to the rate for that plan was reasonable and immaterial to the overall filing.

Standard of Review

Pursuant to Green Mountain Care Board (Board) Rule 2.000 Health Insurance Rate Review, this letter is to assist the Board in determining whether the requested rate is affordable, promotes quality care, promotes access to health care, protects insurer solvency, and is not unjust, unfair, inequitable, misleading, or contrary to the law, and is not excessive, inadequate, or unfairly discriminatory.

Summary of the Data Received

MVPHIC provided the methodology used in premium rate development (Exhibit 2a-2h, Exhibit 3a, and Exhibit 3b) and details pertinent to its actuarial assumptions/experience driving the rate change request. This includes supplemental exhibits comprising historical claim data (split by HDHP and Non-HDHP products) and the membership summary for 36 months grouped into rolling 12 month periods, pricing trend assumptions, experience rating formula (Appendices A-C), and additional supporting exhibits, as requested during review of the filing.

Company's Analysis

1. *Rate Development:* MVPHIC utilized large group claim data (constituting HDHP and EPO/PPO products) for the period from January 2016 through December 2016 and paid through May 2017 as the base period experience. Certain groups were excluded from this analysis because they are not eligible to purchase this product in the future or did not purchase this product in 2017.

   Exhibit 3a illustrates both the claim projection from the experience period to the rating period and the accompanying adjustments applied in deriving the rates for 1Q18.

   From the historical medical experience, claims in excess of $100,000 were replaced with a pooling charge. The pooling charge reflects the average cost of claims in excess of $100,000 and is based on historical experience. The run out for the experience period is five months.

   The adjusted claims were projected forward to the midpoint of the 1Q18 rating period using an annual paid medical trend assumption of 3.4% (elaborated further in item 3 below). MVPHIC's paid medical trend is derived from its proposed allowed cost trend rates and the impact of cost share leveraging[1]. The prescription claims were projected forward to the midpoint of 1Q18 rating period using an annual paid Rx trend of 13.1% (elaborated further in item 4 below).

[1] Leveraging is the result of the fixed nature of deductibles and copays causing the carrier to bear a greater portion of the cost of the medical inflation.

The trended medical and Rx claim cost was further adjusted to develop the projected claim costs as of 1Q18. These adjustments included projected cost of benefit mandates, capitation and non-FFS claim expenses, and Rx rebates. Reflecting all of these adjustments, the quarterly manual rate change suggested by the data was -3.1%.

MVPHIC developed the 2Q18 manual rate by applying one more quarter of trend to the experience period claims. This results in a quarterly rate increase of 1.4% in 2Q18.

2. *Age/Gender Factor Changes:* The rates for this product depend on the demographics of the covered population. The base manual rate projection described above does not take into account changes in demographics. Therefore, it does not reflect the change in the average demographic factor that results from a younger or older enrolled population. Since the prior filing, the demographics of this block have been observed to deviate from past expectations. The demographic factors were re-normalized to reflect the updated experience and decreased by 0.1%.

3. *Medical Trend:* The assumed unit cost trends reflect a combination of known and assumed price increases from MVPHIC's provider network. Utilization trends reflect observed increases in utilization anticipated to continue into the rating period.

Medical Trend	Unit Cost Trend	Utilization Trend	Allowed Trend	Paid Medical Trend
2017	2.1%	0.6%	2.7%	3.0%
2018	2.6%	0.6%	3.3%	3.6%

The allowed cost trends illustrated above are based on allowed charges (reflecting total amount of claims cost paid by the carrier and the policyholder) and do not reflect effective paid trends which reflect the actual claim payment by carrier only. MVPHIC adjusted the allowed cost trends illustrated above to account for the impact of cost share leveraging and derived a total effective paid medical trend factor of 3.4% annually. This effective paid trend factor is used to trend the claim experience from the experience period to the rating period in calculating the projected claim cost for the rating period. For this filing, twenty-four months of trend were used to trend the experience period claims forward to 1Q18.

4. *Rx Trend:* MVPHIC is requesting the annual allowed trends illustrated in the chart below, split by calendar year and by drug tier:

	2017 Trend		2018 Trend	
Tier	Unit Cost	Utilization	Unit Cost	Utilization
Generic	-4.1%	2.9%	1.3%	3.3%
Brand	13.9%	1.5%	13.8%	-1.0%
Specialty	3.8%	6.7%	8.6%	7.3%

The annualized effective paid trend derived from the requested allowed trends in the chart above is 13.1%, which blends the allowed trends to get to the projection period and accounts for cost sharing by the insured (by modeling deductible, copay and coinsurance). This blended annualized figure is used to trend the experience period claim costs to the projection period.

MVPHIC analyzes its pharmacy data by drug category (Generic, Brand, Specialty). Annual trend factors by drug category were supplied by MVPHIC's pharmacy vendor. Those trend factors reflect MVPHIC's business in the state of Vermont.

5. *Administrative Expenses:* As in the prior approved filing, retention charges are added to the blended pure premium in deriving the group required premium. The retention charges include 9.7% of premium for general administrative expense. This is consistent with the prior filing. There is also an assumption of 2.0% for contribution to surplus, and other miscellaneous charges similar to the previous filing, such as the VT Paid Claim Tax. The assumed expenses reflect the return of the ACA Insurer Tax in 2018. The return of the Health Insurer Fee resulted in a rate increase of approximately 0.3% in 1Q 2018.

L&E Analysis

1. *Rate Development:* During our analysis of MVPHIC's rate development methodology, we reviewed the assumptions and adjustments made to the experience data set for large claims and expense loads. We also reviewed the projected loss ratio.

Projection Period (LG in 1Q 2018)		
Period	**Traditional MLR**	**Federal MLR**
1Q 2018	81.2%	86.1%

The pooling charge of 9.2% assumed in this filing is unchanged from the prior filing. As with the prior filing, recent experience has had fewer catastrophic claims than are assumed in this charge. It has been several years since the high-dollar claims on this block were as high as 9.2%. However, MVP provided data from its nationwide experience demonstrating that the proposed pooling charges are reasonable. Due to the highly volatile nature of this assumption, we agree with MVPHIC's assessment that this assumption, by definition, should not respond to short-term fluctuations. Due to the size of the block, the Vermont large group experience alone does not constitute a credible source for this assumption. The current assumption was calculated based on data from 2013 and 2014, which membership was several times as high. Due to medical trend, it is unlikely this factor should decrease over time. We do not recommend changes to the pooling charge at this time.

The adjustment to base period experience for IBNR (Incurred but Not Reported) reserves appear reasonable. Consistent with MVPHIC's other recent filings, data with five months of runout was used in developing these rates.

The proposed rate increase is being applied equally to all medical plans.[2] In effect, this means that the benefit relativities (i.e. the ratio of the premiums between MVPHIC's plans) are based on data that is not current. MVPHIC has indicated that the current relativities were calculated based on claims data from calendar year 2012. In response to an L&E inquiry on this topic, MVPHIC stated that the factors are not being changed due to the size of the block and to minimize the impact on renewing groups. If deductible leveraging or other pressures cause the existing relativities to be discriminatory, changes may be necessary. However, the

[2] As noted above, plan VEHD2-41 also had a slight rate change resulting from a benefit change necessary to maintain QHDHP status.

current factors are likely to result in reasonably equitable results across plans. At this time, we do not recommend any changes to the proposed plan relativities.

We note that the "manual rate cap" included in prior filings has been removed, which is consistent with the Board's order in the prior filing.

2. *Age/Gender Factor Changes:* Since the previous filing, the average age/gender factor of the covered population has been observed to increase by 0.1%. If this change were not corrected for, this would result in excess revenue being collected. To account for this change, MVPHIC has decreased all age/gender factors by the necessary 0.1% to maintain the necessary premium level. When combined with the normalization from the prior filing, this results in an annual decrease to the age/gender factors of 1.4%. The age/gender normalization methodology appears to be reasonable and appropriate.

3. *Medical Trend:* The annual effective paid medical trend factor of 3.4% assumed in this filing represents the most up-to-date provider contracting information available at the time of the filing, resulting in slight changes from prior filings.

   The table below illustrates the allowed trend factors for various benefit categories:

Service Category	2017	2018
Inpatient	4.2%	5.0%
Outpatient & Other Medical	5.0%	5.7%
Physician	-2.0%	-2.3%
Total Medical Trend	**2.7%**	**3.3%**

   We consider the development of medical trend using negotiated unit cost change with providers and GMCB approved rate changes to be reasonable and appropriate. L&E has reviewed the methodology used to combine the assumptions by service category and year into a single trend assumption and found it reasonable. Since the time of this filing, the Board has issued its final determinations regarding hospital budgets for 2018. The Board may wish to incorporate those determinations into the rates for this block of business.

   In this filing, MVP is assuming average annual utilization increases of 0.6%. This assumed increase reflects an observed increase in outpatient and physician services. MVP has provided historical utilization data that shows utilization of all major service categories increased noticeably between 2015 and 2016, even after normalizing for changes in member age. MVP chose to use a logarithmic regression, which implicitly assumes that trend will normalize to zero over time. This methodology resulted in an assumed 0.6% annual utilization trend on average.

   In addition, market data available from other filings indicates that an increase in medical utilization is being observed across the individual and small group market. Based on all information available at this time, the utilization trend included in this filing appears to be reasonable and appropriate.

4. *Rx Trend:* MVPHIC analyzes its pharmacy data by drug category (Generic, Brand, Specialty). Annual trend factors by drug category were supplied by MVPHIC's pharmacy vendor and account for MVPHIC's Vermont specific book of business. The projected annual paid Rx trend is 13.1%.

The Rx trend is assumed to be lower than in the previous filing on an annual basis. The recent actual trends on this block have been highly volatile but have exceeded the current assumption on average over the last two years. The Rx trend appears to be reasonable and appropriate.

MVPHIC is using 2018 drug rebate forecasts provided by the PBM. These forecasts assume that drug rebates will equal $14.94 for 1Q 2018 renewals and $14.98 for 2Q 2018 renewals.

These assumptions appear to be reasonable and appropriate.

5. *Administrative Expenses:* We observed that MVPHIC's assumed general administrative load of 9.7% to be the same as the previous filing. While the assumed administrative load is higher than recent actual expenses on a percentage basis, MVP is anticipating that enrollment in 2018 will be materially lower than in prior years. This decrease in enrollment leads to a higher admin load PMPM because some costs are fixed. In addition, the requested rate decrease increases the impact of fixed administrative costs on a percentage basis. The administrative load appears to be reasonable and appropriate.

Administrative Expense Summary for Large Group AR42 & AR44 Products				
	Member Months	Premium PMPM	Admin PMPM	Expense Ratio
2012	136,049	$335.21	$33.62	10.0%
2013	118,563	$363.04	$39.18	10.8%
2014	97,084	$404.11	$38.31	9.5%
2015	68,766	$432.06	$34.13	7.9%
2016	37,858	$450.19	$36.77	8.2%

The proposed contribution to surplus is 2.0%. In past orders, the Board has reduced the proposed contribution to surplus. We recommend that the solvency analysis performed by DFR be considered if changes are made to this assumption.

MVP has stated that the billback stipulated by 18 V.S.A § 9374 (h)(1) and HCA assessment should be counted as claims for loss ratio purposes. L&E is not opining on the appropriateness of this methodology at this time, as it does not impact the rates for this filing. The projected loss ratio is in excess of the required minimum, both including and not including the billback as a claims expense. We note that if the billback expense is removed from claims in the numerator of the Federal MLR calculation, it should be added to the denominator as an assessment.

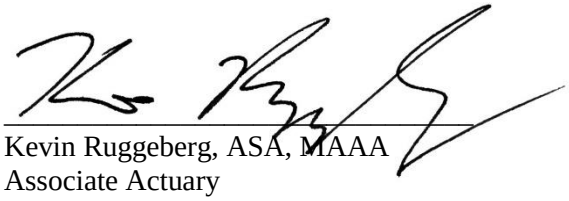
The rate adjustment reflecting the return of the Health Insurer Fee, a rate increase of 0.3% in 1Q 2018, appears to be reasonable and appropriate.

The administrative expense assumptions appear to be reasonable and appropriate.

Recommendation

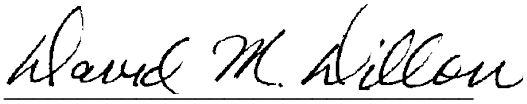
L&E believes that this amended filing does not produce rates that are excessive, inadequate, or unfairly discriminatory. Therefore, L&E recommends that the Board approve the filing as amended.

Sincerely,



Kevin Ruggeberg, ASA, MAAA
Associate Actuary
Lewis & Ellis, Inc.

Jacqueline B. Lee, FSA, MAAA
Vice President
Lewis & Ellis, Inc.



David M. Dillon, FSA, MAAA, MS
Vice President & Principal
Lewis & Ellis, Inc.

ASOP 41 Disclosures
The Actuarial Standards Board (ASB), vested by the U.S.-based actuarial organizations[3], promulgates actuarial standards of practice (ASOPs) for use by actuaries when providing professional services in the United States.

Each of these organizations requires its members, through its Code of Professional Conduct[4], to observe the ASOPs of the ASB when practicing in the United States. ASOP 41 provides guidance to actuaries with respect to actuarial communications and requires certain disclosures which are contained in the following.

Identification of the Responsible Actuary
The responsible actuaries are:

- Kevin J. Ruggeberg, ASA, MAAA Associate Actuary at Lewis & Ellis, Inc. (L&E).
- Jacqueline B. Lee, FSA, MAAA, Vice President at Lewis & Ellis, Inc. (L&E).
- David M. Dillon, FSA, MAAA, MS, Vice President & Principal at Lewis & Ellis, Inc. (L&E).

These actuaries are available to provide supplementary information and explanation. The actuaries also acknowledge that they may be acting as an advocate.

Identification of Actuarial Documents
The date of this document is October 26, 2017. The date (a.k.a. "latest information date") through which data or other information has been considered in performing this analysis is October 26, 2017.

Disclosures in Actuarial Reports

- The contents of this report are intended for the use of the Green Mountain Care Board. The authors of this report are aware that it will be distributed to third parties. Any third party with access to this report acknowledges, as a condition of receipt, that they cannot bring suit, claim, or action against L&E, under any theory of law, related in any way to this material.
- Lewis & Ellis Inc. is financially and organizationally independent from the health insurance issuers whose rate filings were reviewed. There is nothing that would impair or seem to impair the objectivity of the work.
- The purpose of this report is to assist the Board in assessing whether to approve, modify, or disapprove the rate filing.
- The responsible actuaries identified above are qualified as specified in the Qualification Standards of the American Academy of Actuaries.
- Lewis & Ellis has reviewed the data provided by the issuers for reasonableness, but we have not audited it. L&E nor the responsible actuaries assume responsibility for these items that may have a material impact on the analysis. To the extent that there are material inaccuracies in, misrepresentations in, or lack of adequate disclosure by the data, the results may be accordingly affected.
- We are not aware of any subsequent events that may have a material effect on the findings.
- There are no other documents or files that accompany this report.
- The findings of this report are enclosed herein.

[3] The American Academy of Actuaries (Academy), the American Society of Pension Professionals and Actuaries, the Casualty Actuarial Society, the Conference of Consulting Actuaries, and the Society of Actuaries.

[4] These organizations adopted identical *Codes of Professional Conduct* effective January 1, 2001.

Actuarial Findings
The actuarial findings of the report can be found in the body of this report.

Methods, Procedures, Assumptions, and Data
The methods, procedures, assumptions and data used by the actuary can be found in body of this report.

Assumptions or Methods Prescribed by Law
This report was prepared as prescribed by applicable law, statues, regulations and other legally binding authority.

Responsibility for Assumptions and Methods
The actuaries do not disclaim responsibility for material assumptions or methods.

Deviation from the Guidance of an ASOP
The actuaries have not deviated materially from the guidance set forth in an applicable ASOP.